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Physician perspectives of abortion advocacy: findings from a mixed-methods study

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ABSTRACT

Objective Our aim was to assess physicians' perspectives of what constitutes abortion advocacy and the skills needed to be effective in their efforts to safeguard legal abortion.

Methods Alumni from a physician training programme for sexual and reproductive health advocacy completed a cross-sectional survey including questions on perceived skills needed for effective advocacy. The research team conducted in-depth interviews (IDIs) with alumni, based on their level of engagement in advocacy. We present descriptive statistics for survey data and themes identified in the interview data using techniques informed by grounded theory.

Results Of the survey respondents (n=231), almost a third (28.6%; n=66) felt the most important media skill they learnt was the ability to stay on message. The most important policy skill was communicating effectively with policymakers (47.0%; n=108), followed by distilling evidence for policymakers and laypeople (13.0%; n=30). In the IDIs (n=36), participants reported activities such as media interviews as clear examples of advocacy, but also considered implementing institutional policies and abortion provision to be advocacy. They discussed how individual comfort and capacity for advocacy activities may change over time, given personal and professional considerations. Regardless of the type of activity, physicians valued strategic communication and relationship-building skills.

Conclusions Based on our findings, training programmes that seek to mobilise physician advocates to advance sexual and reproductive health and rights should work with trainees to create a tailored advocacy plan that fits their personal and professional lives and goals. Regardless of the types of advocacy activities physicians focus on, strategic communication may be central in skills-based training.

Key messages

⇒ Physician advocacy is a competency in medical training programmes, but the field has not clearly established what 'physician advocacy' entails for those who provide sexual and reproductive healthcare.
⇒ Physicians in an advocacy training programme considered myriad activities as abortion advocacy, including institutional advocacy and providing abortion care, and their engagement in such activities may change depending on their personal and professional circumstances.
⇒ Training programmes should help trainees to identify which type(s) of advocacy activities best fit their lives, to create individually tailored advocacy plans, recognising that this may change over time.

INTRODUCTION

The American Medical Association envisions physician advocacy as the promotion of "social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being".[1] In medical education programme guidelines, the accrediting body in the United States (US) includes a competency of "advocating for quality patient care and optimal patient care systems".[2] Yet, the field has not clearly established what sexual and reproductive health (SRH) 'physician advocacy' entails and what skills are needed to be effective.

Physicians are regarded as honest and ethical community members.[3 4] They understand evidence supporting medical practices and their patients' needs and lived experiences. This positions them

as valuable and effective advocates for systems-level changes on patients' behalf. Recently, medical training programmes have integrated advocacy into their curricula.[5] However, there are no standard guidelines and programmes have heterogenous approaches to training advocacy skills.

Physician advocates in all areas of health are important but are particularly critical for SRH-related legislative decisions that affect their ability to provide essential care including abortion. Historically in the US, physicians and activists functioned in opposition, then as 'uneasy' allies, with differing perspectives on the medicalisation of abortion. More recently, many physicians identify as abortion activists and align with the progressive position of the second-wave feminist movement,[6] and continue to as the movement advances from being led by majority white women with a 'pro-choice' stance to the present-day feminist wave of reproductive justice advocacy led by women of colour.[7]

Given the increased restrictions on abortion in the US,[8 9] physician advocacy for SRH is imperative. SRH advocacy requires specialised training that physicians may not receive through formal medical education. Several advocacy training programmes in the US, including Physicians for Reproductive Health's (PRH) Leadership Training Academy (LTA),[10] seek to address this gap by offering US-based physicians media, communication, leadership and policy skills needed to be effective SRH advocates.

As part of a mixed-methods evaluation of the LTA programme, we assessed alumni physicians' perspectives on what it means, and the skills needed, to be an effective physician advocate for abortion and other SRH care. Our findings can inform curriculum development for programmes that seek to equip clinicians to advocate for reproductive health.

METHODS

From 2018–2020 our research team conducted an external mixed-methods evaluation of the LTA, a 9-month intensive training programme designed to prepare physicians to become self-directed advocates for SRH. The LTA began in 2004, and was initially only open to family planning fellows. In 2010, all medical specialties could apply with annual cohorts of 20–43 practising physicians. The LTA curriculum offers instruction in leadership development, media and communications, public policy, medical education and professional association advocacy, via two week-long trainings, a single-day training (in-person prior to the pandemic) and 6 monthly webinars. While the mode, content and speakers of the curriculum have evolved over time, these main pillars of advocacy training have remained. PRH staff also provide one-on-one support to alumni for advocacy preparation.

Our evaluation included a survey to assess alumni perspectives about the curriculum, engagement across four curricular advocacy domains (media, legislative policy, organisational and medical education) and sociodemographic characteristics. In 2018, we sent the survey electronically to all alumni (n=326). Respondents received a US$35 gift card for survey completion. For the survey analysis, we present descriptive statistics of reports on the most important media/policy/leadership skill they learnt from the LTA to be an effective abortion advocate.

In 2019, we conducted in-depth interviews (IDIs) with programme alumni using results from the cross-sectional survey to inform development of the interview guide. We selected a subsample of approximately 10% of survey respondents for IDIs, based on their self-reported level of engagement in advocacy activities (stratified by those who reported what we characterised as low, medium and high levels of engagement in SRH media-, legislative policy- and organisational/medical education-related advocacy, ensuring representation across levels of advocacy). We used the programme's database to identify alumni who did not complete the survey (n=61), stratified by level of engagement, to include six non-responders who spanned cohort years. Levels of engagement were based on the number and types of advocacy activities over the last year for survey responders and considered all activities (from the database) for non-responders. We approached 44 alumni to enrol at least 10 alumni within each engagement level, distributed across a range of self-reported hostile/friendly environments and years practising medicine. We asked about advocacy/leadership activities and perspectives on advocacy engagement. Two authors (MM, DR) and an assistant conducted interviews by telephone or video. All interviewees signed consent forms. The interviewer recorded the IDIs (average 62 min, range 42–89 min) and they were transcribed. Each participant received a US$50 gift card.

To analyze the IDIs, we used techniques informed by grounded theory. Analysis began with a list of potential codes derived from the interview guide, which was modified and expanded to allow for emergent codes and themes per grounded theory methodology. The analytic team coded an initial group of transcripts followed by discussion to refine the code structure. We finalised the code structure after several rounds of coding, discussion and revision.[11 12] We applied the final codebook to all transcripts. Concurrently, analysts wrote memos identifying emerging ideas and met several times to discuss a thematic structure for the findings. To maintain confidentiality, one author (TRE) associated with the programme did not have access to the raw data. We use the term 'participant' for IDIs and 'respondent' for surveys (pseudonyms are used).

The IDI and survey data were analysed iteratively to triangulate findings. Specific themes from the IDI analysis suggested related questions that we subsequently

explored in the survey data. Findings from the respective datasets were examined relative to the other.

The team all identify as female, non-clinicians who support access to abortion and SRH care. The City University of New York Institutional Review Board approved this study (Protocol #2018–1045). The study's central aim helps to improve patients' access to necessary SRH care. Given the nature of the programme evaluation, patients were not involved in this study.

RESULTS

For the survey, 231 respondents completed 75% or more of the survey questionnaire and are included (response rate: 71%). Respondents spanned cohort years from 2004 to 2018 and the majority identified as women (91.3%; n=211). The most represented clinical specialties were obstetrics and gynaecology (67.5%; n=156) and family medicine (25.5%; n=59), and the majority (87.3%; n=200) had provided abortions in the past year. Of the 44 approached for IDIs, 36 participated (response rate: 82%). Participants spanned cohort years 2006–2018; most represented clinical specialties in obstetrics and gynaecology (58.3%; n=21) and family medicine (33.3%; n=12). Using survey data for those who completed it (n=30), most (n=26) identified as women and four as men, and most (n=29) had provided abortions in the last year.

The two main themes that emerged from the IDI analysis were: (1) physicians considered myriad activities as advocacy and (2) advocates required strategic communication, connections and commitment to be effective. We found that abortion advocacy varied by the context an individual was working in and their comfort level, and that this changed over the course of their careers.

Myriad activities considered advocacy

From the IDIs, physician alumni relayed that there were multiple ways to engage in advocacy – both as vocal and "quiet" advocates – and individuals should focus on ways that capitalise on their strengths, comfort level and alignment with their professional and personal lives. They acknowledged this may shift with time, training and circumstances. Overall, many noted the training programme made it possible for each person to leverage their own strengths and interests, acknowledging that some aspects of advocacy resonate with some more than others. Each person demonstrated a different comfort level, from speaking publicly in the media or with legislators, to getting involved in one's professional institution to effect change, and all of these activities played a valuable role in SRH advocacy.

Patti, an obstetrician/gynaecologist who reported "high" levels of advocacy engagement stated:

> I can make these different choices about what my advocacy looks like at different points and be very effective in that way.

Similarly, Lily, a family medicine physician with "low" advocacy levels, noted:

> I do consider myself a reproductive health advocate, or an abortion advocate. That can happen… in the exam room while you're doing an abortion, it can be as a physician among a group of physicians in any number of settings…. It can mean being a local leader… in local organisations… this is the level that I have time for and I'm comfortable with at this point… the very outspoken advocacy is a very small part of it.

Activities that participants considered abortion advocacy ranged from "out loud" advocacy (eg, meeting with legislators and participating in media interviews) to "quiet" or "undercover" advocacy (eg, assuming leadership in professional medical organisations). Laura, an obstetrician/gynaecologist with "medium" advocacy levels, reflects this notion:

> …similar to other movements, I think that you do need those people who are really, really vocal and out front and leading the charge and they don't mind being the centre of attention…. We also need the people who are just making incremental progress day-by-day.

Participants considered abortion provision itself to be an important form of advocacy. This also included training medical residents to provide abortions, organising SRH care at one's institution, and updating guidelines within medical organisations. Robert, a family medicine provider, with "medium" levels of advocacy, said:

> I think doing abortion work is itself advocacy, and I think it's hard to underestimate how much sacrifice individual providers make to keep their role within the abortion community.

Thus, a wide range of advocacy activities were valued by participants and considered necessary to safeguard SRH care. Although the sentiment that a range of activities was considered advocacy was shared across engagement levels, those considered "low" or "medium" levels shared this view more than those considered "high".

Strategic communication, connections and commitment needed for effective advocacy

Results from the IDIs and survey demonstrated that participants felt that strategic communication skills (eg, storytelling, explaining data and information in non-medical/scientific ways, becoming comfortable in uncomfortable spaces) were key to being an effective abortion advocate. Such skills may be used in presentations to colleagues, meetings with policymakers or media engagement. One participant, Rafaela, an obstetrician/gynaecologist with "high" levels of engagement, noted:

> Part of it is being able to explain the medical background in a way that makes sense to people that don't have that background.

In the IDIs, participants shared that advocates need to retain commitment to the cause that included consistent, active engagement and staying abreast of changes. In addition, they discussed the need for establishing relationships and connections with policymakers and changemakers.

Ultimately, many articulated a complex combination of attributes, such as compassionate, ethical storytelling that would frame individual patients' needs for an abortion; some noted this within a reproductive justice and intersectional framework.[7] The comment below from Robert, a family medicine physician with a "medium" level of advocacy engagement, captured this theme:

> Just coming from an RJ [reproductive justice] mindset, as a physician, so much of my storytelling has nothing to do with someone's abortion. It has everything to do about their goals, their vision for their life and what they want to achieve…. getting comfortable with the language of storytelling… is the skill I think the LTA best teaches.

The value of communication skills and making connections was also noted by survey respondents. Almost a third (28.6%; n=66) of respondents felt the most important media skill learnt was being able to stay on message, followed by establishing key talking points (22.5%; n=52) and incorporating patient stories in media work (15.2%; n=35). Respondents felt the most important policy skill was communicating effectively with policymakers (47.0%; n=108), followed by distilling evidence for policymakers and laypeople (13.0%; n=30). For leadership skills, they felt many were important, including self-awareness in leadership (18.3%; n=42) and effective and positive communication (15.7%; n=36).

DISCUSSION

In this mixed-methods study of advocacy training programme alumni, we found that alumni considered myriad activities as advocacy, and that their advocacy work may change over their lives based on their skills, comfort level, and personal and professional circumstances. Physician participants acknowledged the importance of some "out loud" abortion advocates who are active in the media and/or communicate with policymakers. However, given the highly politicised nature of abortion, providing abortions was also viewed as critical advocacy work. Indeed, participants we had deemed as "low" engagement may have been providing abortions, which we had not considered as advocacy. The LTA may provide a community that relies on one another for emotional support, to help prevent burnout in abortion provision, indirectly upholding its mission to promote abortion access.

Strategic communication skills were viewed as critical for advocacy. Additional training focused in these areas can help trainees feel comfortable engaging in activities such as on-camera interviews, that come with the added vulnerability and real potential of being ambushed or threatened by abortion opponents.

Our findings may be valuable to a broad range of training programmes that seek to mobilise SRH physician activists to ensure reproductive rights. Such programmes include clinician advocacy training and medical education programmes seeking to fulfil the competency to advocate for changes that promote patient well-being.[2] Our findings suggest that training programmes should consider working with trainees to identify advocacy activities that best fit their lives, recognising these may change over time. Specialised communications training, with an emphasis on storytelling and relationship building, may be a beneficial curricular component. Programmes that promote skills applicable to a range of advocacy activities can allow trainees to choose the mode of engagement that best suits their strengths, comfort and life circumstances.

This study was limited in that the sample consisted of physicians only; thus, the perspectives of other medical providers in abortion care are missing. We were not able to measure how effective respondents were as advocates. Our sample was also limited to physicians who completed a specific post-residency advocacy training programme and is therefore not generalisable. Alumni were from different cohorts with an evolving curriculum, so their reports of most valuable skills learnt might differ. The survey question asked may not represent all the skills that respondents felt were needed to be an effective abortion advocate; their understanding of needed skills may be circumscribed to what they learnt in the LTA. Nonetheless, because these physicians self-selected into the LTA, they likely have some level of experience to understand needed skills. A main strength of this study was our mixed-methods design that resulted in a high level of alignment across data (eg, perception of skills needed for advocacy) as well as rich findings on what constitutes advocacy (eg, how "low" activity from survey data was challenged with new ideas from IDIs). This process of triangulation not only confirmed findings across the data, but also informed a deeper understanding of physician perspectives on skills needed for effective abortion advocacy.

As advocacy and medical training programmes work to strengthen advocacy training in their curricula, considering a range of advocacy activities and how these may change over a physician's career may be important. With increasing restrictions on abortion access in the US and globally, training programmes focused on SRH advocacy are critical to help ensure reproductive health.

Correction notice This article has been corrected since it was first published. The open access licence has been updated to CC BY. 31st May 2023.

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Patient consent for publication Not applicable.

Ethics approval This study involved human participants and was approved by City University of New York Institutional Review Board (Protocol #2018-1045). Participants gave informed consent to participate in the study before taking part.

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